		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042069

Facility Name: Alden of Old Town East

Address: 108 S. First Street (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630) 671-1703 **Fax #** (630) 671-1706

IDPA ID Number: 36-3966584

Date of Initial License for Current Owners: 05/09/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Steven M. Kroll
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,671			5,671	13
14	TOTALS	5,671			5,671	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.11%

D. How many bed-hold days during this year were paid by Public Aid?
85 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 07/06/98

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 07/06/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	44,697	3,461		48,158	494	48,652		48,652			1
2	Food Purchase		27,884		27,884	(2,449)	25,435	2,310	27,745			2
3	Housekeeping	8,887	4,312		13,199	21	13,220		13,220			3
4	Laundry	3,698	3,215		6,913		6,913		6,913			4
5	Heat and Other Utilities			14,862	14,862		14,862	(22)	14,840			5
6	Maintenance	1,903		16,927	18,830		18,830	958	19,788			6
7	Other (specify):*											7
8	**TOTAL General Services**	59,185	38,872	31,789	129,846	(1,934)	127,912	3,246	131,158			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	271,454	18,183	1,949	291,586		291,586	(1,779)	289,807			10
10a	Therapy											10a
11	Activities		2,972	19,457	22,429		22,429		22,429			11
12	Social Services	32,789			32,789		32,789		32,789			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	304,243	21,155	25,406	350,804		350,804	(1,779)	349,025			16
	C. General Administration											
17	Administrative	49,287			49,287		49,287		49,287			17
18	Directors Fees											18
19	Professional Services			98,882	98,882		98,882	(89,766)	9,116			19
20	Dues, Fees, Subscriptions & Promotions			4,195	4,195	(2,297)	1,898	(641)	1,257			20
21	Clerical & General Office Expenses	30,719	4,257	6,655	41,631	2,297	43,928	3,003	46,931			21
22	Employee Benefits & Payroll Taxes			57,557	57,557	1,934	59,491	10,867	70,358			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,198	6,198	(2,520)	3,678	1,259	4,937			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			9,497	9,497		9,497	944	10,441			26
27	Other (specify):* **Bad debt**			3,232	3,232		3,232	(3,232)				27
28	**TOTAL General Administration**	80,006	4,257	186,216	270,479	(586)	269,893	(77,566)	192,327			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	443,434	64,284	243,411	751,129	(2,520)	748,609	(76,099)	672,510			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden of Old Town East #0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation					3,838	3,838	41,062	44,900			30
31	Amortization of Pre-Op. & Org.							369	369			31
32	Interest			130,361	130,361		130,361	(40,983)	89,378			32
33	Real Estate Taxes			12,000	12,000	(12,000)		12,384	12,384			33
34	Rent-Facility & Grounds			94,819	94,819	12,000	106,819	(106,753)	66			34
35	Rent-Equipment & Vehicles			2,145	2,145	2,520	4,665	1,874	6,539			35
36	Other (specify):* Mortg. Insurance			3,838	3,838	(3,838)		6,429	6,429			36
37	**TOTAL Ownership**			243,163	243,163	2,520	245,683	(85,618)	160,065			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,285	5,055	7,340		7,340	(1,504)	5,836			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		8		8		8	(8)	(0)			41
42	Provider Participation Fee			62,342	62,342		62,342		62,342			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,293	67,397	69,690		69,690	(1,512)	68,178			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	443,434	66,577	553,971	1,063,982		1,063,982	(163,229)	900,753			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(120,168)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(119)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	80	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,232)	27		24
25	Fund Raising, Advertising and Promotional	(686)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (124,125)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(38,636)		34
35	Other- Attach Schedule	(468)	pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (39,104)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (163,229)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden of Old Town East

ID# **0042069**

Report Period Beginning: **01/01/2002**

Ending: **12/31/2002**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BACK OUT: HEALTHCARE ASSOC PAC FEES	$ (77)	20	1
2	BACK OUT:CLOTHING /GIFT SHOP ITEMS	(8)	41	2
3				3
4	Back out utility late fee	(383)	5	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(468)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town East # 0042069 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(119)	0	0	2,429	0	0	0	0	0	0	0	2,310	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(383)	0	361	0	0	0	0	0	0	0	0	(22)	5
6	Maintenance	0	0	960	0	0	0	(2)	0	0	0	0	958	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(502)	0	1,321	2,429	0	0	(2)	0	0	0	0	3,246	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(1,762)	(17)	0	0	0	0	0	0	(1,779)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(1,762)	(17)	0	0	0	0	0	0	(1,779)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,662	(91,428)	0	0	0	0	0	0	0	0	(89,766)	19
20	Fees, Subscriptions & Promotions	(683)	0	42	0	0	0	0	0	0	0	0	(641)	20
21	Clerical & General Office Expenses	0	0	2,627	374	2	0	0	0	0	0	0	3,003	21
22	Employee Benefits & Payroll Taxes	0	0	10,867	0	0	0	0	0	0	0	0	10,867	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,259	0	0	0	0	0	0	0	0	1,259	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	944	0	0	0	0	0	0	0	0	0	944	26
27	Other (specify):*	(3,232)	0	0	0	0	0	0	0	0	0	0	(3,232)	27
28	**TOTAL General Administration**	(3,915)	2,606	(76,633)	374	2	0	0	0	0	0	0	(77,566)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,417)	2,606	(75,312)	1,041	(15)	0	(2)	0	0	0	0	(76,099)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town East # 0042069 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	28,497	12,564	0	1	0	0	0	0	0	0	41,062	30
31	Amortization of Pre-Op. & Org.	0	210	158	0	0	1	0	0	0	0	0	369	31
32	Interest	(120,168)	74,259	4,917	0	0	9	0	0	0	0	0	(40,983)	32
33	Real Estate Taxes	0	11,962	422	0	0	0	0	0	0	0	0	12,384	33
34	Rent-Facility & Grounds	0	(106,819)	66	0	0	0	0	0	0	0	0	(106,753)	34
35	Rent-Equipment & Vehicles	0	0	1,874	0	0	0	0	0	0	0	0	1,874	35
36	Other (specify):*	0	6,429	0	0	0	0	0	0	0	0	0	6,429	36
37	**TOTAL Ownership**	(120,168)	14,538	20,001	0	1	10	0	0	0	0	0	(85,618)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,504)	0	0	0	0	0	(1,504)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(8)	0	0	0	0	0	0	0	0	0	0	(8)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(8)	0	0	0	0	(1,504)	0	0	0	0	0	(1,512)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(124,593)	17,144	(55,311)	1,041	(14)	(1,494)	(2)	0	0	0	0	(163,229)	45

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See page 6k		See page 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent income	$ 106,819	Alden of Bloomingdale Limited Partnership	100.00%	$	$ (106,819)	1
2	V	32	Revenue from investments	10,345	Alden of Bloomingdale Limited Partnership			(10,345)	2
3	V	19	Audit		Alden of Bloomingdale Limited Partnership		1,233	1,233	3
4	V	19	Misc. Adm. Expenses		Alden of Bloomingdale Limited Partnership		429	429	4
5	V	33	Real estate taxes		Alden of Bloomingdale Limited Partnership		11,962	11,962	5
6	V	26	Insurance expense		Alden of Bloomingdale Limited Partnership		944	944	6
7	V	32	Interest on mortgage payable		Alden of Bloomingdale Limited Partnership		68,350	68,350	7
8	V	32	Interest on operating loss loan		Alden of Bloomingdale Limited Partnership		16,254	16,254	8
9	V	36	Mortgage insurance premium		Alden of Bloomingdale Limited Partnership		6,429	6,429	9
10	V	30	Depreciation		Alden of Bloomingdale Limited Partnership		28,497	28,497	10
11	V	31	Amortization		Alden of Bloomingdale Limited Partnership		210	210	11
12	V								12
13	V								13
14	Total			$ 117,164			$ 134,308	$ * 17,144	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	employee benefits	$	Alden Management Services	100.00%	$ 10,867	$ 10,867	15
16	V	19	profess. Fees	92,588	Alden Management Services		1,160	(91,428)	16
17	V	21	g & a		Alden Management Services		2,627	2,627	17
18	V	5	utilities		Alden Management Services		361	361	18
19	V	6	maintenance		Alden Management Services		960	960	19
20	V	24	auto/travel		Alden Management Services		1,259	1,259	20
21	V	20	subscriptions/etc		Alden Management Services		42	42	21
22	V	30	depreciation		Alden Management Services		12,564	12,564	22
23	V	31	amortization		Alden Management Services		158	158	23
24	V	33	real estate tax		Alden Management Services		422	422	24
25	V	34	rent		Alden Management Services		66	66	25
26	V	35	rent-equip/vehicles		Alden Management Services		1,874	1,874	26
27	V	32	interest		Alden Management Services		4,917	4,917	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 92,588			$ 37,277	$ * (55,311)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Tube feeding	$	Pyramid Health Care Services	100.00%	$ 2,429	$ 2,429	15
16	V	10	Nursing supplies	1,775	Pyramid Health Care Services		13	(1,762)	16
17	V	39	Per diem/other supplies		Pyramid Health Care Services				17
18	V	21	General & admin		Pyramid Health Care Services		374	374	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,775			$ 2,816	$ * 1,041	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$	Forum Extended Care II	100.00%	$	$	15
16	V	10	House stock	72	Forum Extended Care II		55	(17)	16
17	V	39	IV		Forum Extended Care II				17
18	V	22	Employee benefits		Forum Extended Care II				18
19	V	21	G & A		Forum Extended Care II		2	2	19
20	V	32	Interest		Forum Extended Care II				20
21	V	33	Real estate taxes		Forum Extended Care II				21
22	V	30	Depreciation		Forum Extended Care II		1	1	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72			$ 58	$ * (14)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 5,157	Community Physical Therapy	100.00%	$ 3,653	$ (1,504)	15
16	V	32	Interest		Community Physical Therapy		9	9	16
17	V	31	Amortization		Community Physical Therapy		1	1	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,157			$ 3,663	$ * (1,494)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	maintenance cost	$ 716	Alden Bennett Construction	100.00%	$ 714	$ (2)	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 716			$ 714	$ * (2)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A Schlossberg	President		100.00	361,196	0.224	0.56	SALARY	$ 2,016	17-1	1
2	Lauren Magnusson	Coordinator		A	91,203	0.224	0.56	SALARY	509	17-1	2
3	Terry Magnusson	Maintenance Supr		A	85,340	0.224	0.56	SALARY	476	17-1	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,002		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8A (also on page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Prudential		x	mortgage	$6,066.00	1997	$ 873,700	$ 855,539	9/2037	7.9700	$ 68,350	1
2	Cambridge		x	operating loss loan	$6,367.00	6/2002	339,267	337,905	9/2037	6.8600	16,254	2
3												3
4												4
5	Operating Loan		x	operations	$1,403.08	5/1/02	224,295	223,395	9/1/37	6.8300	10,193	5
	Working Capital											
6	Related party - AMS	X		working capital							4,917	6
7												7
8	Related party - CPT	X		working capital							9	8
9	TOTAL Facility Related				$13,836.08		$ 1,437,262	$ 1,416,839			$ 99,723	9
	B. Non-Facility Related*											
10	Bloom Assoc interest income on replacement reserve to offset interest expenses										(10,345)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,345)	14
15	TOTALS (line 9+line14)						$ 1,437,262	$ 1,416,839			$ 89,378	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 6,429 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	11,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	11,562	2
3. Under or (over) accrual (line 2 minus line 1).	$	62	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	11,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	11,962	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	4,140	8
	1998	9,337	9
	1999	10,978	10
	2000	11,120	11
	2001	11,435	12

Accrual based on 3% increase over prior year bill.

Amount recorded as paid in 2002 represents 1/3 of all real estate tax parcels assessed to Bloomingdale Assoc. entities. Old Town East = $11,435.06, Old Town West = $12,113.78, Trails = $11,136.64 TOTAL = $34,685.48 1/3 of Total = $11,561.83

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden of Old Town East COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0042069

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-15-201-020	Nursing home facility	$ 11,435.06	$ 11,435.06
2.		Related Party - Alden Management	$ 76,052.00	$ 422.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 87,487.06	$ 11,857.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior brick veneer Frame wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	14,400	1995	$ 150,868	1
2					2
3	TOTALS	14,400		$ 150,868	3

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 18,359	$	22	$	$	$ 18,359	4
5	16		1997	1997	934,861	23,372	40	23,372		129,165	5
6											6
7											7
8											8
	Improvement Type**										
9	TV Modules			1999	1,775	355	5	355		1,242	9
10	Sprinkler system			2001	2,345	235	10	235		391	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 957,340	$ 23,961		$ 23,961	$	$ 149,157	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 957,340	$ 23,961		$ 23,961	$	$ 149,157	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,334	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	0	40	0		183	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,013,914	$ 25,768		$ 25,768	$	$ 195,264	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 143,705	$ 13,905	$ 13,905	$	varies	$ 60,557	71
72	Current Year Purchases	12,171	872	872		varies	872	72
73	Fully Depreciated Assets	39,228	566	566		varies	39,228	73
74								74
75	TOTALS	$ 195,104	$ 15,342	$ 15,342	$		$ 100,657	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/van/bus	'98-'02 dodge	'98-'02	$ 12,336	$ 3,790	$ 3,790	$	3	$ 9,992	76
77										77
78										78
79										79
80	TOTALS			$ 12,336	$ 3,790	$ 3,790	$		$ 9,992	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,372,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 44,900	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 44,900	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 305,913	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$ n/a	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party- cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,145 Description: copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	non-patient transport		$ 210.00	$ 2,520	17
18	various	various	156.17	1,874	18
19					19
20					20
21	TOTAL		$ 366.17	$ 4,394	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nurses on sight

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 2,114	$		$ 2,114	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			848			848	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			2,093			2,093	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PAGE 16A	# of prescrpts			586			586	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PAGE 16A				195			195	13
14	TOTAL			$		$ 5,836	$		$ 5,836	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden of Old Town East **#** 0042069 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 2,110	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,561)	303,954	333,276	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		43,036	5
6	Prepaid Insurance	1,043	5,199	6
7	Other Prepaid Expenses	588	1,859	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from IDPA	24,631	24,631	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 330,215	$ 410,111	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		221,765	11
12	Long-Term Investments		12,566	12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	4,120	4,120	15
16	Equipment, at Historical Cost	25,137	102,019	16
17	Accumulated Depreciation (book methods)	(12,102)	(140,959)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,155	$ 1,277,860	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 347,370	$ 1,687,971	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 54,520	$ 67,649	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,720	6,720	28
29	Short-Term Notes Payable		7,242	29
30	Accrued Salaries Payable	23,074	23,074	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,351	5,351	31
32	Accrued Real Estate Taxes(Sch.IX-B)		11,900	32
33	Accrued Interest Payable		7,606	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expense	4,366	6,761	36
37	related parties	346,635	346,635	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 440,666	$ 482,938	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	223,395	1,409,595	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Owner's advances		19,095	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 223,395	$ 1,428,691	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 664,060	$ 1,911,628	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (316,690)	$ (223,657)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 347,370	$ 1,687,971	48

***(See instructions.)**

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (424,802)	1	
2	Restatements (describe):		2	
3	External audit adjustments made after 2001 cost report		3	
4	was submitted . These have no effect on prior year	473	4	
5	report: Bad debt, medicare revenues (non-allowables)		5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (424,329)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	107,639	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 107,639	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (316,690)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,089,415	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,089,415	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	old a/p write offs	443	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 443	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,089,858	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	129,846	31
32	Health Care	350,804	32
33	General Administration	270,479	33
	B. Capital Expense		
34	Ownership	243,163	34
	C. Ancillary Expense		
35	Special Cost Centers	7,348	35
36	Provider Participation Fee	62,342	36
	D. Other Expenses (specify):		
37	Related party salary allocations	(81,763)	37
38	transactions not included on this page, but included		38
39	on page 3&4.		39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 982,219	40
41	**Income before Income Taxes (line 30 minus line 40)****	107,639	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 107,639	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,359	2,423	62,516	25.80	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	22,038	23,020	213,505	9.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,300	4,510	42,027	9.32	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,062	1,129	6,989	6.19	18
19	Laundry	247	247	3,698	14.97	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,922	2,027	32,790	16.18	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	31,928	33,356	$ 361,525 *	$ 10.84	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	353	18,735	11-3	44
45	Social Service Consultant	14	722	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	367	$ 23,841		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Dang, D	administrator	0	18,364
Moller,D	administrator	0	19,450
various executives/assist admin	administration	0	11,472
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,287

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AMS	Management Fees	$ 92,590
BDO Seidman	Accounting Fees	3,548
Ken Fisch / Greenberg	Legal Fees	2,483
Talx	Workers Comp Consulting	96
Medi.Com	Billing Consultant	22
U S Gas & Energy Corp	Energy	144
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 98,882

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,295
Unemployment Compensation Insurance	6,004
FICA Taxes	29,857
Employee Health Insurance	7,929
Employee Meals	2,449
Illinois Municipal Retirement Fund (IMRF)*	
Dental, Life, Relations & Misc	71
Background Cks, Drug Test & 401K	886
related party - Ams	10,867
TOTAL (agree to Schedule V, line 22, col.8)	$ 70,358

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Ill Health Care Assoc.	915
Near North Insurance	300
related party - Ams	42
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,257

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Misc, Gas & Repairs	2,723
related party - Ams	1,259
Seminar Expense	
Comprehensive Therapeutic	325
Hcfa Lab. Program / O.C.C. / Other	630
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,937

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Alden of Old Town East **#** 0042069 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IL Healthcare Assoc. $915**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,685** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **62,342**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **2,449** Has any meal income been offset against related costs? **no** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **BDO Seidman, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.